Franklin County Cooperative
Health Improvement Program

Affidavit of Domestic Partnership Termination

I _____ certify that I previously filed the appropriate Affidavit with
Franklin County Employee Name (Print)

the Franklin County Benefits & Wellness Office to establish a domestic partnership, and I now inform the County that

_____ is no longer my domestic partner as of
Name of former Domestic Partner (Print)

_____.
Date

I understand that my former domestic partner and my former domestic partner's child(ren), if applicable, are no longer eligible for benefits provided by the Franklin County Cooperative Health Improvement Program as of the date identified above as the date our domestic partnership ended.

I also certify that I will provide my former domestic partner with a copy of this Affidavit at the following address:

_____
Name of former Domestic Partner (Print)

_____
Street Address

_____
City State Zip Code

Note: If applicable, the Franklin County Benefits & Wellness Office will use this address to mail Health Plan Continuation of Coverage information to your former domestic partner, unless another address is provided.

I understand that another Affidavit of Domestic Partnership to establish a new domestic partnership cannot be filed until six (6) months after this domestic partnership has been terminated. I understand this form may be supplied to my agency's Human Resources Department.

_____ _____ _____
Signature of Employee Date of Birth Date

Employee's Social Security Number (required): _____ Agency:_____

_____ _____
Signature of Benefits & Wellness Representative Date

Please return form(s) to:

Franklin County Benefits & Wellness Office
373 S. High Street, 25th Floor, Columbus, Ohio 43215
Phone: 614.525.5750 Fax: 614.525.5515
E-mail: benefits@franklincountyohio.gov
Website: http://BeWell.FranklinCountyOhio.gov